DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 9/16/12

PRINTED: 08/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445076	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC HEALTHCARE, MCMINNVILLE	928 OLD SMITHVILLE RD MC MINNVILLE, TN 37110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 022 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to mark exits with readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. The finding included: Observation on 7/30/12 at 12:16 PM revealed the exit access doors in the dining room were not marked with "Exit" signs. This finding was verified by the maintenance staff and the facility administrator during the exit conference on 7/30/12.	K 022	K022 1. **Corrected Actions Accomplished.** The Maintenance Supervisor and Maintenance Assistant installed 3 new Exit Lights indicating the exit access doors in the dining room on 8/08/12. 2. **How We Have Identified Other Potential Areas Affected by the Same Practice and What Corrective Action Taken.** Maintenance Supervisor and Maintenance Assistant examined all exit doors for proper signage. No further exit doors were found without required signage. 3. **What Done to Ensure That the Practice Does Not Recur.** The Maintenance Supervisor and Administrator will ensure "Exit" signs are in place with any remodel or building modifications. 4. **The Corrective Action Will Be Monitored To Ensure the Practice Will Not Recur.** The Maintenance Supervisor will check all exit signs are in place and working monthly times 4 months to ensure substantial compliance is achieved. Results will be reported to the QA Committee (Administrator, Director of Nursing, Medical Director, Health Information and Assistant Director of Nursing). **Completion Date:** 8/08/12	
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K 038		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
T. Walther	Administrator	8-17-12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 038	Continued From page 1 This STANDARD is not met as evidenced by: Based on observations, it was determined the facility failed to provide exits readily accessible at all times. The findings included: 1. Observation on 7/30/12 at 10:50 AM revealed the facility had exit access from the therapy room through the conference room. Path through the confrence room was obstructed by table and chairs. 2. Observation on 7/30/12 at 12:07 PM revealed the exit discharge from the 400 hall did not have all-weather hard surface to the public way. 3. Observation on 7/30/12 at 12:08 PM revealed the exit discharge from the courtyard did not have all-weather hard surface to the public way. These findings were acknowledged by the maintenance staff and the facility administrator during the exit conference on 7/30/12.	K 038	K038 1. **Corrected Actions Accomplished.** The Maintenance Supervisor removed the "Exit" sign from the doorway leading into the conference room from the Therapy Gym on 7/31/12. A concrete sidewalk will be installed leading from the 400 hall exit and courtyard on *9/16/12*. 2. **How We Have Identified Other Potential Areas Affected by the Same Practice and What Corrective Action Taken.** The Maintenance Supervisor and Maintenance Assistant checked all existing "Exit" were readily accessible and those outside did have all-weather hard surface to all public ways. 3. **What Done to Ensure That the Practice Does Not Recur.** All staff were in-serviced on 8/30/12 to ensure all exits were readily accessible at all times. 4. **The Corrective Action Will Be Monitored To Ensure the Practice Will Not Recur.** Maintenance Supervisor and Maintenance Assistant to check all exits are accessible monthly times 4 months to ensure substantial compliance. Results will be reported to the QA Committee (Administrator, Director of Nursing, Medical Director, Health Information and Assistant Director of Nursing). **Completion Date:**	9/16/12
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, it was determined the	K 062		

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K 062	Continued From page 2 facility failed to maintain the sprinkler system in reliable operating condition. The finding included: Observation on 7/30/12 at 11:21 AM revealed shower curtains in the shower rooms in the 200 and 100 halls obstructing the sprinklers. This finding was acknowledged by the maintenance staff and the facility administrator during the exit conference on 7/30/12.	K 062	K062 1. **Corrected Actions Accomplished.** The Maintenance Supervisor replaced shower curtains in the 200 and 100 hall shower rooms with curtains that have an 18-inch mesh to allow adequate sprinkler coverage of all areas of shower rooms on 7/31/12. 2. **How We Have Identified Other Potential Areas Affected by the Same Practice and What Corrective Action Taken.** The Maintenance Supervisor and Maintenance Assistant checked all areas of center to assure all sprinkler heads were unobstructed on 7/31/12. 3. **What Done to Ensure That the Practice Does Not Recur.** All staff were in-serviced on 8/30/12 on keeping sprinkler heads unobstructed. 4. **The Corrective Action Will Be Monitored To Ensure the Practice Will Not Recur.** Maintenance Supervisor and Maintenance Assistant will check all areas in the center to assure sprinkler heads are unobstructed weekly times four weeks and then monthly times three months to ensure substantial compliance. Results will be reported to the QA Committee (Administrator, Director of Nursing, Medical Director, Health Information and Assistant Director of Nursing). **Completion Date:**	7/31/12
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to store medical gas in accordance with NFPA 99. The findings included: 1. Observation on 7/30/12 at 10:47 AM revealed	K 076		

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K 076	Continued From page 3 seven unsecured oxygen cylinders in the oxygen storage room in the therapy room. 2. Observation on 7/30/12 at 10:49 AM revealed the oxygen cylinders in the oxygen storage room in the therapy room were not identified as full or empty. These findings were acknowledged by the maintenance staff and the facility administrator during the exit conference on 7/30/12.	K 076	K076 1. **Corrected Actions Accomplished.** The Maintenance removed the unsecured oxygen cylinders from the Therapy Storage room on 7/30/12. The Station One charge nurse checked and marked the cylinders correctly on 7/30/12. 2. **How We Have Identified Other Potential Areas Affected by the Same Practice and What Corrective Action Taken.** Maintenance Supervisor, Maintenance Assistant and Respiratory Therapist checked all rooms in building for unsecured cylinders and for proper labeling of cylinders. No findings. A larger oxygen cylinder rack was installed in the Therapy Storage Area for oxygen cylinders. 3. **What Done to Ensure That the Practice Does Not Recur.** All staff were in-serviced on proper storage and labeling of oxygen cylinders on 8/14/12, 8/16/12 and 8/30/12. 4. **The Corrective Action Will Be Monitored To Ensure the Practice Will Not Recur.** Maintenance Supervisor, Maintenance Assistant and charge nurses will check storage and patient rooms for proper labeling and storage of oxygen cylinders weekly times 4 weeks to ensure substantial compliance. Results will be reported to the QA Committee (Administrator, Director of Nursing, Medical Director, Health Information and Assistant Director of Nursing). **Completion Date:**	7/30/12
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: National Fire Protection Association 101 Life Safety Code: 8.2.3.2.4.2 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows: (1) The space between the penetrating item and the fire barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet one of the following conditions:	K 130		

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K 130	Continued From page 4 a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (3) *Insulation and coverings for pipes and ducts shall not pass through the fire barrier unless one of the following conditions is met: a. The material shall be capable of maintaining the fire resistance of the fire barrier. b. The material shall be protected by an approved device that is designed for the specific purpose. (4) Where designs take transmission of vibration into consideration, any vibration isolation shall meet one of the following conditions: a. It shall be made on either side of the fire barrier. b. It shall be made by an approved device that is designed for the specific purpose. Based on observations, it was determined the facility failed to comply with the Life Safety Code. The findings included: Observation on 7/30/12 at 10:54 AM revealed penetrations in the fire barriers in the following locations: a. Conduit through fire wall adjacent to therapy room. b. Above conduit in fire wall by room 211 c. Above pipe through fire wall by room 316 d. Around communication conduit and above other pipe in fire wall by shower room in 400 hall e. Around conduit in fire wall by room 118	K 130	**K130** 1. **Corrected Actions Accomplished.** The Maintenance Supervisor and Maintenance Assistant sealed penetrations around the conduit through the fire wall adjacent to the Therapy Gym, around the conduit in the fire wall by room 211, around the pipe through the fire wall by room 316, around the communication conduit and above the other pipe in the fire wall by shower room in the 400 hall and around the conduit in the fire wall by room 118 with Flame Stopper, Smoke, Fire & Draft Stop on 8/3/12. 2. **How We Have Identified Other Potential Areas Affected by the Same Practice and What Corrective Action Taken.** The Maintenance Supervisor and Maintenance Assistant checked all fire walls for any additional penetration on 7/30/12. No findings. 3. **What Done to Ensure That the Practice Does Not Recur.** Maintenance Supervisor and Maintenance Assistant will regularly check fire walls for penetrations through regular preventative maintenance checks. 4. **The Corrective Action Will Be Monitored To Ensure the Practice Will Not Recur.** Maintenance Supervisor and Maintenance Assistant will check fire-walls monthly for three months and then quarterly for nine months to ensure substantial compliance. Results will be reported to the QA Committee (Administrator, Director of Nursing, Medical Director, Health Information and Assistant Director of Nursing). **Completion Date:**	8/03/12

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K 130	Continued From page 5 These findings were acknowledged by the maintenance staff and the facility administrator during the exit conference on 7/30/12.	K 130		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observations, it was determined the facility failed to maintain the electrical wiring and equipment. The findings included: 1. Observation on 7/30/12 at 11:22 AM revealed the faceplate on an electrical outlet in room 200 had broken off. 2. Observation on 7/30/12 at 11:52 AM revealed back to back power strips running between the Director of Nursing office and the MDS Nurse office. 3. Observation on 7/30/12 at 12:06 PM revealed a multi-plug adapter in use in room 412. 4. Observation on 7/30/12 at 12:10 PM revealed a junction box was missing a cover in the mechanical room by the front offices. These findings were acknowledged by the maintenance staff and the facility administrator during the exit conference on 7/30/12.	K 147	K147 1. **Corrected Actions Accomplished.** The Maintenance Assistant replaced the faceplate on the electrical outlet in room 200, removed the power strip from the Director of Nurse's office, removed the multi-plug adapter from room 412 and replaced the missing junction box cover on 7/31/12. 2. **How We Have Identified Other Potential Areas Affected by the Same Practice and What Corrective Action Taken.** The Maintenance Assistant checked all electrical outlets, checked all offices for proper use of power strips, checked all rooms for improper use of multi-plug adapters, and checked all junction boxes on 7/31/12. No additional findings. 3. **What Done to Ensure That the Practice Does Not Recur.** All staff was in-serviced on proper use of power-strips and multi-plug adapters on 8/30/12. 4. **The Corrective Action Will Be Monitored To Ensure the Practice Will Not Recur.** Maintenance Supervisor and Maintenance Assistant will check for electrical outlet faceplates, proper use of power-strips, use of multi-plug adapters and junction box covers monthly for 4 months to ensure substantial compliance. Results will be reported to the QA Committee (Administrator, Director of Nursing, Medical Director, Health Information and Assistant Director of Nursing). **Completion Date:**	7/31/12